Biennial Report

SFY 2002-2003

Indiana Family and Social Services Administration
Division of Mental Health and Addiction

"People helping people help themselves"

Division of Mental Health and Addiction

Biennial Report
SFY 2002-2003

Writing/Editing: Natalie Angel
Graphic Design: Sue Bell

Indiana Government Center South
402 West Washington Street, Room W353
Indianapolis, IN 46204-2739
www.in.gov/fssa/servicemental

May 2004

Table of Contents

Executive Summary

Suzanne F. Clifford, Director

Mission

"To ensure that Indiana citizens have access to appropriate mental health and addiction services that promote individual self-sufficiency."

The Indiana Family and Social Services Administration's Division of Mental Health and Addiction (DMHA) is pleased to report on our services, progress and future plans in this, our fifth biennial report.

As the director for the Division of Mental Health and Addiction, I have been inspired by the hard work and dedication that our staff, advocates, and providers display each day. I would also like to recognize my predecessor, Janet Corson, and wish her a happy retirement. The 2002-2003 biennium was a time of great promise in the fight against stigma and breaking down barriers to treatment. The National New Freedom Commission on Mental Health focused critically needed attention on the challenges faced by people with mental illness and addiction throughout the nation and here in Indiana.

As you read this report, you will see our focus on integrating and enhancing services for children via Systems of Care teams, serving consumers in the least restrictive setting, and our priority of expanding the use of Evidence Based Practices for adults, such as Assertive Community Treatment (ACT) and Integrated Dual Diagnosis Treatment (IDDT).

This report is dedicated to our consumers and their families. We are committed to the goal of consumer recovery.

Suzanne Clifford

Suzanne F. Clifford, Director
Division of Mental Health and Addiction
Family and Social Services Administration
www.in.gov/fssa/servicemental

1 Responsibilities

- Policy Oversight
- Scope of Illness
- Our Consumers
- Hoosier Assurance Plan
- Prevalence Rates

Policy Oversight

A critical role of The Indiana Family and Social Services Administration's Division of Mental Health and Addiction is to provide policy oversight for the publicly funded mental health and addiction services system. The Division is responsible for establishing criteria used to determine consumer eligibility, ensure that service providers comply with state guidelines, and to assure the quality of services required by the continuum of care as defined in Indiana statute. The functions of the Division can be divided into two areas, state psychiatric hospitals and community services. The Division operates six state psychiatric hospitals and contracts with community mental health centers and addiction treatment providers to offer mental health and addiction treatment services in the community. The Division also provides alcohol, tobacco and drug prevention programs in the community.

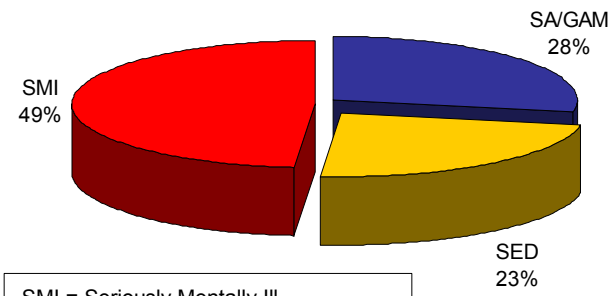
Hoosier Assurance Plan

- 78% of persons served by the HAP have a family income that is less than $10,000 per year
- 90% have a family income that is less than $15,000 per year

The Hoosier Assurance Plan (HAP) is the primary method by which the Division of Mental Health and Addiction (DMHA) funds community mental health and addiction services. Within the Hoosier Assurance Plan, the Division strives to insure availability of quality services to all eligible citizens. DMHA certifies and contracts with Community Mental Health Centers (CMHCs) and addiction treatment providers, which are nonprofit organizations that are responsible for providing mental health and addiction services. In 2003, 31 community mental health centers provided services statewide. Under the Hoosier Assurance Plan, CMHCs must provide a legislatively mandated "continuum of care" which is a range of services that community mental health centers and addiction providers must make available to consumers. The continuum of care includes individual treatment planning, 24 hour crisis intervention, case management, outpatient services, acute stabilization services, residential and day treatment, family support services, medication monitoring and services to prevent unnecessary hospitalization.

The Hoosier Assurance Plan is intended to serve the Indiana population in greatest need of mental health and addiction services. HAP funds are targeted to low-income persons, defined as those at or below 200% of the federal poverty level. The four primary populations targeted by DMHA are: adults with serious mental illness (SMI), children with serious emotional disturbance (SED), persons with chronic addiction (SA), and persons with a compulsive gambling disorder (GAM).

Persons Served by Agreement Type
SFY 2002-2003



SMI = Seriously Mentally Ill
SED = Seriously Emotionally Disturbed
SA/GAM = Substance Abuse/Gambling

Scope of Illness

The need for effective, available mental health and addiction treatment is clear. Major depression is the leading cause of disability worldwide among all people over the age of five. Mental illness, including suicide, accounts for over 15% of the burden of disease in established market economies, such as the U.S. This is more than the disease burden caused by all cancers.[1]

Addiction also takes a large toll on society. The social cost of drug and alcohol addiction treatment in the U.S. is estimated at $294 billion per year in lost productivity and costs associated with law enforcement, health care, criminal justice, welfare, and other programs and services.[2] The good news is that treatment works – and for every $1 invested in addiction treatment, there is a return of $4 to $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of $12 to $1.[3]

Major depression is the leading cause of disability world-wide among persons age five and older.[1]

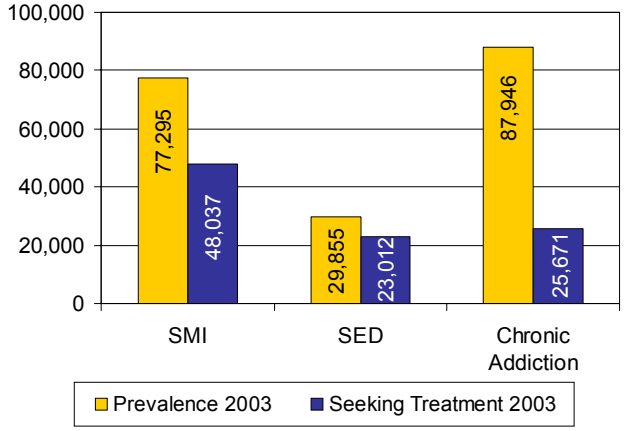
Indiana Prevalence Rates

Prevalence numbers are based on federal census information and represent the estimated number of people in a population who are affected by either a mental illness or substance abuse disorder. Since the Hoosier Assurance Plan is available to only those individuals who are at or below 200% of the federal poverty level, the Division limits prevalence estimates to that population. The table above shows the estimated number of Hoosiers, at or below 200% of the federal poverty level, that have a Serious Mental Illness (SMI), Serious Emotional Disturbance (SED) or Chronic Addiction.

Estimated Prevalence for Indiana Residents at or Below 200% of the Federal Poverty Level

Seriously Mentally Ill	77,295
Seriously Emotionally Disturbed	29,855
Chronic Addiction	87,946

Hoosiers Seeking Services Compared to Prevalence of Illness (at or below 200% of the Federal Poverty Level)

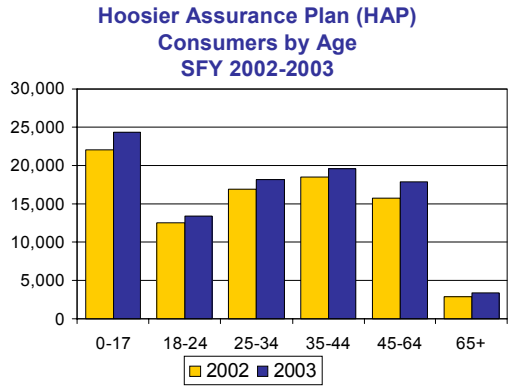


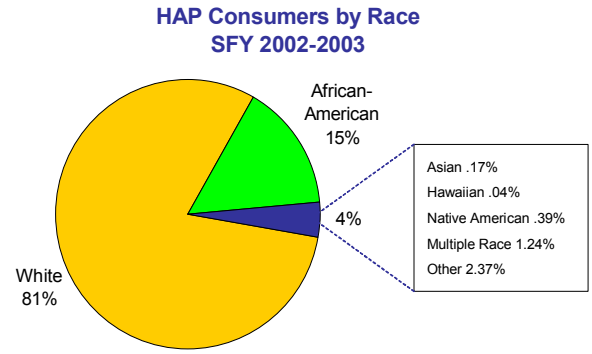
The graph to the left illustrates the number of Hoosiers, at or below 200% of the federal poverty level, estimated to have a SMI, SED, or Chronic Addiction compared with the number of HAP eligible Hoosiers that sought treatment at any of the 31 CMHCs that contract with the Division. This comparison illustrates the potential increase in demand for services that could overwhelm Indiana's capacity to provide treatment to all income eligible Hoosiers who seek treatment.

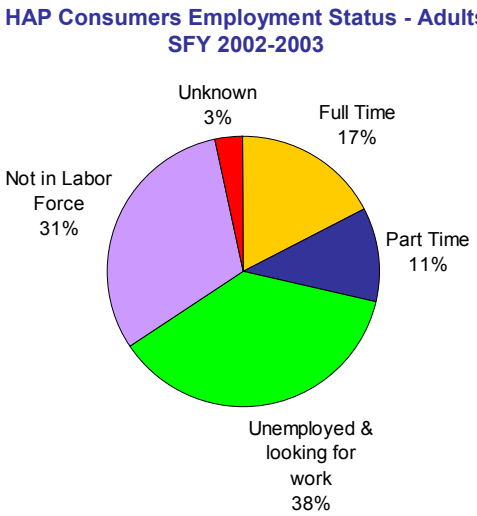
[1] Murray CJL, Lopez AD, eds. *The global burden of disease and injury series, volume 1: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020.* Cambridge, MA 1996.
[2] Coffey, R.M., Ph.D., et al, *National Estimate of Expenditures for Substance Abuse Treatment, 1997.* U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Medstat Group, February 2001.
[3] *Principles of Drug Addiction Treatment: A Research-Based Guide.* NIH Publication No. 00-4180. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, printed October 1999/reprinted July 2000.

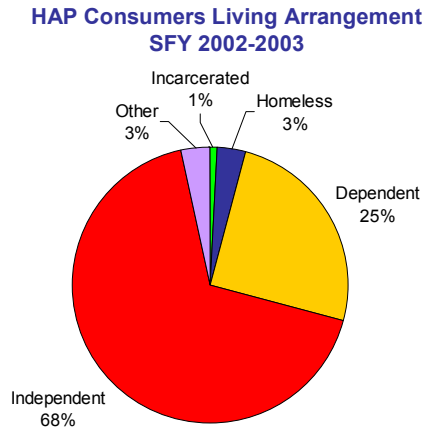
Our Consumers

The Division of Mental Health and Addiction serves all Hoosier Assurance Plan (HAP) eligible persons who seek treatment. These charts provide a demographic profile of our consumers. As the charts show, the Division serves consumers of all ages from very young children to adults over the age of 65. The majority of those seeking services are white, while 15% of those seeking services are African-American and 4% of those seeking services represent other race categories. Living arrangement and employment status are the key factors to improving outcomes. Stable, appropriate housing is necessary for consumers to begin their work toward recovery. Appropriate housing can include a group home, shared apartment, living with family, or a single family home. Employment is also important for consumers in their recovery efforts. Increasing the number of people who take part in supported employment is a priority of the Division as we head into the 2004-2005 biennium.









Employment Status

Full-time: working 35 or more hours per week
Part-time: working 34 or fewer hours per week
Unemployed: looking for work during the last 30 days or laid off from a job
Not in Labor Force: not looking for work during the last 30 days or a homemaker, student, disabled, retired or in an institution

Living Arrangement

Homeless: no fixed address; includes living in a shelter, in a car, on the street, etc.
Dependent: includes those in nursing homes, foster care, residential facilities, state institutions, or other supervised living.
Independent: those in a home, apartment, or mobile home
Incarcerated: includes those in a jail or correctional setting and those on home detention, work release or juvenile detention

2 Budget

- Medicaid
- State Psychiatric Hospital Budget

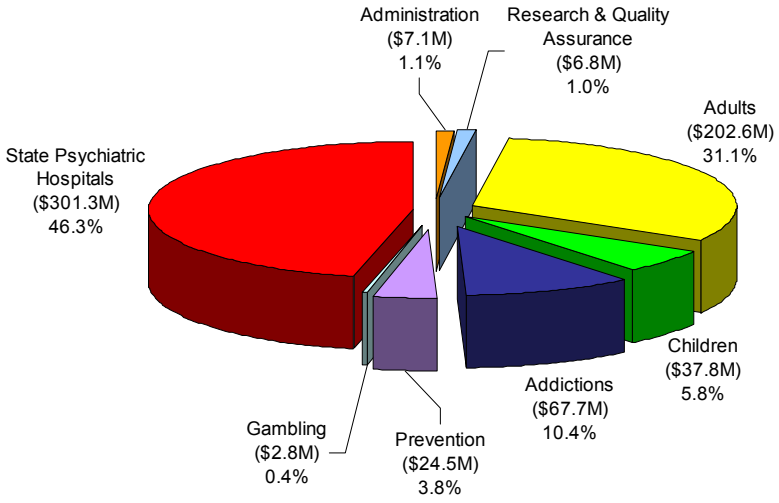
The Division of Mental Health and Addiction (DMHA) budget is a combination of state and federal funds. The state funds are appropriated by the state legislature every two years in the biennial budget. The legislature makes specific appropriations for community services for children with serious emotional disturbance (SED), services for adults with serious mental illness (SMI), services for persons with chronic addiction, the six state psychiatric hospitals, and DMHA administration. Key focus areas for funding in 2002 and 2003 were community-based services such as Systems of Care for children with SED and Assertive Community Treatment (ACT) teams for adults with SMI. These intensive community-based services allow children and adults who are at risk of hospitalization to be treated in their communities. Community funds were also used to increase community services so that individuals were able to move out of the state psychiatric hospitals reducing the amount of money spent on state psychiatric hospitals in the second year of the biennium.

DMHA Biennium Appropriations
SFY 2002 and 2003
Operating Budget (in millions)

	SFY 2002	SFY 2003
Community Based Services	165.6	169.8
Community Based Mental Health - Adults	99.3	103.3
Community Based Mental Health - Children	18.9	18.9
Community Based Addiction	47.4	47.6
State Hospital Services	152.2	149.1
TOTAL SERVICES	**317.8**	**318.9**
Administration	3.5	3.5
Research & Quality Assurance	3.4	3.4
TOTAL DMHA Budget	**324.7**	**325.8**

Federal funds in the Division's budget for community services come from the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Mental Illness (MI) Block Grant. The SAPT Block Grant accounts for more than 70% of the Division's budget for substance abuse treatment and over 90% of the Division's budget for prevention. The MI Block Grant represents 11% of the Division's budget for adults with serious mental illness and 25% of the budget for children with serious emotional disturbance.

DMHA Biennium Budget, State Fiscal Years 2002-2003
(includes transferred funds)



The Hoosier Assurance Plan requires providers to serve all eligible people who seek treatment. However, the Division is not able to fund services for all who seek treatment. The table on the right shows the number of HAP eligible Hoosiers with a SMI, SED, or Chronic Addiction. The table shows the number of Hoosiers who received funded services, those who received unfunded services, and those who are estimated to need services but did not seek treatment.

Number of Hoosiers Qualified for the Hoosier Assurance Plan in SFY 2003

	Indiana Prevalence HAP eligible	Received DMHA funded hospital services	Received DMHA funded community services	Entered the DMHA community system, but **did not have DMHA funding**	Services needed, but did not seek DMHA treatment & **did not have DMHA funding**
Adults with Serious Mental Illness and those w/Co-occurring Addiction and Serious Mental Illness	77,295 projected	1,537 (2%)	24,220 (31%)	23,817 (31%)	27,721 (36%) projected
Children with Serious Emotional Disturbances	29,855 projected	171 (1%)	9,974 (33%)	13,038 (44%)	6,672 (22%) projected
Hoosiers with a Chronic Addiction	87,946 projected	283 (0.3%)	18,882 (21%)	6,789 (8%)	61,992 (71%) projected

Medicaid

The Division of Mental Health and Addiction has been able to maximize state appropriated service dollars utilizing funds received from the Medicaid Rehabilitation Option (MRO) program. Medicaid is a health care program for low-income and disabled individuals that is jointly financed by the state and federal governments. Each state administers its own program within broad federal guidelines. In Indiana, the Division of Mental Health and Addiction, under an interagency agreement with the Office of Medicaid Policy and Planning (OMPP), is responsible for the administration of certain community-based services for adults and children with mental illness and/or chronic addiction under the Medicaid Rehabilitation Option. In SFY 2003, Community Mental Health Centers (CMHCs) had total MRO expenditures of $207.4 million. More than 57,000 adults and children received MRO services in SFY 2003. The MRO program will continue to grow, as long as unmatched state dollars are available.

State Hospital Operating Costs for 2002 and 2003

State Hospital	SFY 2002 Operating Cost	SFY 2003 Operating Cost
Evansville Psychiatric Childrens Center	$2,983,802	$2,926,254
Evansville State Hospital	$26,077,637	$25,277,966
Larue Carter Memorial Hospital	$22,673,400	$21,852,094
Logansport State Hospital	$37,987,014	$39,134,827
Madison State Hospital	$26,655,872	$22,193,403
Richmond State Hospital	$32,145,588	$32,335,088
Totals	**$148,523,313**	**$143,719,632**

State Psychiatric Hospital Budget

The six state psychiatric hospitals operate with individual budgets. The Division uses available federal funds to offset operating costs. Federal funds come from a variety of sources. Federal Medicare and Medicaid payments and federal disproportionate share funds are the largest sources of federal funds currently available to state psychiatric hospitals. Hospitals also receive some funds from patients, private insurance and other programs that pay part of a patient's hospital costs.

3 State Psychiatric Hospitals

- Role of Hospitals
- Grants
- Awards
- Accreditation
- Accomplishments
- Satisfaction Surveys

Role of Hospitals


Richmond State Hospital Treatment Clinic

Indiana's State Psychiatric Hospitals serve many roles in their respective communities. They are inpatient treatment units for those who need an intensive level of treatment; they are top-notch research facilities for students and professionals in the fields of mental health and addiction; and they are good neighbors in their community, adding to the local economy and culture. The state hospital system serves adults with mental illness (including adults who are mentally retarded/developmentally delayed, adults who have chronic addictive disorders, adults who are deaf or hearing impaired, and adults who have forensic involvement), and children and adolescents with serious emotional disturbances. Patients are admitted to a state hospital only after a screening by a Community Mental Health Center (CMHC) responsible for providing case management to the patient in both the hospital and community. CMHCs also are responsible for facilitating a patient's transition from the hospital back to the community or other appropriate setting. Transitional care services at the hospitals are used to help patients make a smooth transition to community living, and staff for these services work with the patient's CMHC on treatment planning and discharge.

Six State Psychiatric Hospitals

Evansville State Hospital, Evansville, Indiana

Developed a treatment mall which centralizes programming into an environment that is specifically designed for treatment. It enables patients to exit from their units throughout the day in order to take part in treatment programs. This allows a patient to receive more treatment and helps to reduce the sense of isolation that can exist when patients are kept on the unit for all daily activities.

Richmond State Hospital, Richmond, Indiana

Dialectical Behavior Therapy was added to services for patients receiving substance abuse services. Training on Dialectical Behavior Therapy was also offered to Community Mental Health Centers.

Madison State Hospital, Madison, Indiana

A new patient, deaf and fluent in American Sign Language (ASL), was admitted to the hospital. This new patient highlighted the need for staff to learn American Sign Language. A training program in ASL was developed for staff and expanded to include several patients who share a unit with the deaf patient. The program created the opportunity for better communication between staff and patient as well as the opportunity for increased socialization between patient and peers.

Logansport State Hospital, Logansport, Indiana

The Aim Build Choose project at Logansport State Hospital guides patients in making good choices. The program focuses on patient education regarding proper nutrition, exercise, and life choices. Special training was provided regarding educating patients with diabetes as well as the general patient population.

Evansville Psychiatric Children's Center (EPCC), Evansville, Indiana

Community associations in Evansville often donate time and resources for recreational activities for the children at EPCC. Events range from the local Harley Davidson motorcycle club hosting an annual party for the children to the Junior Mental Health Association of Vanderburgh County sponsoring a Santa's Workshop where the children can pick out gifts for their families.

Larue D. Carter Memorial Hospital, Indianapolis, Indiana

Indy race car legend Art Pollard made the kids at Carter Hospital an important part of his schedule each May. In 2003, Carter Hospital made Art Pollard an important part of their campus by naming the kids' playground area in honor of him. The Art Pollard Fund was established by his friends and relatives soon after his death. This year, the annual Art Pollard Picnic was held in conjunction with a sign unveiling and a visit to the hospital by Art's son, Mike. Also visiting was Art Pollard's cousin, Brad Pollard, who works at MicroSoft on the X-Box team. Brad brought an X-Box and five racing games as a donation...one that the kids were thrilled to receive.

New Building/Facility Development/Awards

Several new construction projects were underway in SFY 2002-2003.

- Richmond State Hospital opened a new Clinical Treatment Center at an August 21, 2002 dedication. The Clinical Treatment Center received a Community Improvement Award from the Richmond-Wayne County Chamber of Commerce.
- Logansport State Hospital made significant progress on the development of the new Isaac Ray Unit. This new building will expand forensic capacity at the hospital.
- The largest building project of the year was the newly constructed Evansville State Hospital, which won the Golden Trowel Award for their innovative use of materials.
- Development began on the Southeast Regional Center at Madison State Hospital. The center will be complete in early 2005.

Hospital Accomplishments

- A major undertaking shared by all six state psychiatric hospitals was the effort to meet federal Health Insurance Portability and Accountability Act (HIPAA) requirements. One goal of the 1996 Act is to protect the security and confidentiality of health information. For the hospitals, this involved upgrading data systems and training staff on privacy standards.

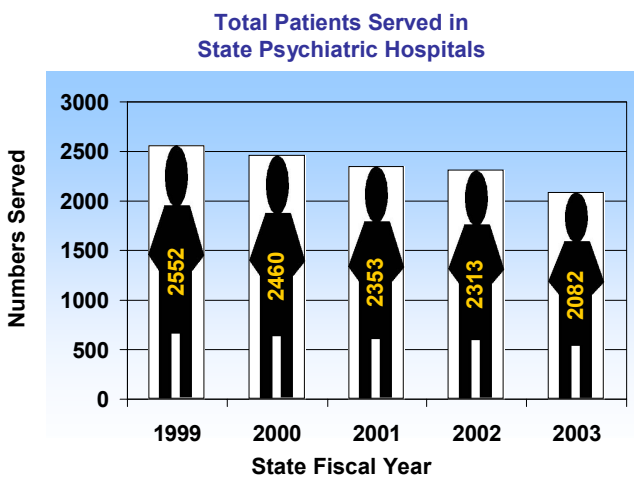
- A cost saving initiative was undertaken at Logansport State Hospital during the biennium. An effort was made to reduce the amount spent on overtime wages for psychiatric and special attendants. To reduce overtime, a team analyzed the cause of overtime and made recommendations to improve shift and unit assignments and days off for staff. The hospital staffing policy was also changed. These efforts saved over $450,000 in State Fiscal Year 2003 and will save even more in SFY 2004.

Hospital Based Grants

- The Stamm Family Foundation Grant of $10,000 provides education services for the school age children at Richmond State Hospital.
- The Wayne County Tobacco Prevention and Cessation Coalition Grant of $10,000 provides education and support to employees and clients to help reduce the number of smokers and the effects of environmental smoke at Richmond State Hospital.
- A Literacy Grant of $1,500 provides educational and leisure materials for the patient library program at Madison State Hospital.
- A Literacy Grant of $1,500 per year provides educational and leisure materials for the patient library program at Logansport State Hospital.
- A Heritage Research Grant from the Indiana Historical Society and the Indiana Humanities Council of $2,937 to Logansport State Hospital.

Numbers Served in State Psychiatric Hospitals
State Fiscal Years 2002-2003

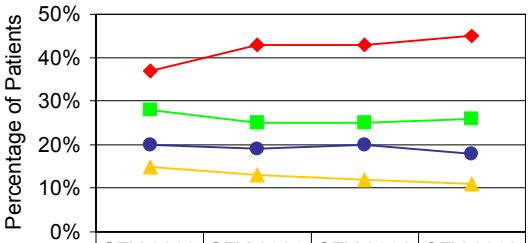
2002			2003	
# Children Served in DMHA Hospitals			**# Children Served in DMHA Hospitals**	
Ages of Children	# Served		Ages of Children	# Served
5-9	35		5-9	22
10-14	105		10-14	98
15-17	83		15-17	73
Total	**223**		**Total**	**193**
# Adults Served in DMHA Hospitals			**# Adults Served in DMHA Hospitals**	
Ages of Adults	# Served		Ages of Adults	# Served
18-24	260		18-24	267
25-44	1,076		25-44	941
45-64	645		45-64	591
65+	109		65+	90
Total	**2,090**		**Total**	**1,889**



The total number of patients being served in the state hospitals has shown a steady decline for several years. This decline is due to the increase in community capacity and the efforts to serve consumers in the least restrictive setting that is appropriate for each consumer.

The length of time for patients present in the state hospitals on June 30 of each year also shows the shift in the use of the hospital setting from that of long term stay to acute intensive treatment and a return to the appropriate community setting.

Length of Time for Patients Present as of June 30th



	SFY 2000	SFY 2001	SFY 2002	SFY 2003
<1 year	37%	43%	43%	45%
1-4 years	28%	25%	25%	26%
5-9 years	15%	13%	12%	11%
10+ years	20%	19%	20%	18%

Hospital Accreditation

The six state psychiatric hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and maintain certification of all Intermediate Care Facilities for the Mentally Retarded (ICF/MR). To maintain JCAHO accreditation, all hospitals are required to participate in a performance measurement program. This is accomplished through participation in the National Research Institute Performance Measurement System, which provides a framework within which the state psychiatric hospitals can identify and implement consistent measures of performance and outcomes. Consistent measurement produces the ability to benchmark the critical indicators of performance and outcomes, leading to the identification and implementation of processes that improve client recovery.

Hospital Satisfaction Surveys

Satisfaction surveys are sent to all patients upon their discharge from a state psychiatric hospital. For children and adolescents, surveys are sent to the parent/guardian. In addition to being used locally to monitor program performance and customer relations, a copy is sent to the Division of Mental Health and Addiction (DMHA) Central Office where analysis comparing the hospitals and identifying particular strengths and weaknesses can be used for quality improvement. Survey questions address program effectiveness, availability and cooperation of staff, treatment team meetings, treatment outcomes, safety, and more. Survey results are discussed with each hospital at quarterly governing body meetings and hospitals are expected to study and report on action plans to address problem areas. Hospitals that score below a set criteria must develop strategies focused on improvement.

A day in the state hospital

The day starts early at Larue Carter Hospital. Patients wake at 6:30 a.m., dress, make their bed, and are ready for breakfast in the cafeteria by 7:30 a.m. Three meals a day are served in the hospital cafeteria, shared by both patients and staff. At 8:30 a.m. each unit gathers for a unit meeting. The day shift staff start at 8:00 a.m. and meet with patients to discuss patient progress, events, and the schedule for the day. At this meeting, patients are given their "activity card" that shows their schedule for the day. After the unit meeting, morning medications are distributed. The rest of the day is filled with scheduled educational, therapeutic or physical activity. Patients are assigned to classes that run in 8-week sessions. Classes cover topics such as nutrition, stress management, using free time constructively and "how to have a conversation." Skills training courses include cooking class or ceramics. Around 4 p.m. the evening staff gather for another unit meeting. All staff are kept up-to-date on the day's activities. Evening activities are usually more relaxing and fun for patients with hospital-wide bingo or a movie. Each Friday night, the hospital hosts a dance. By 11:00 p.m. patients need to be in their room engaged in a quiet activity. The goals of treatment at Larue D. Carter Memorial Hospital, as well as the other five state psychiatric hospitals, are to assist individuals in achieving the skills that are necessary to manage symptoms, develop routines, and to successfully prepare them for life in the community.

Mike

Mike has had difficulties since he was a young child. As a 4 year-old, he was sexually abused by a babysitter. By the age of 7, he was a very angry child who was often in trouble for acting out. When he began to hurt himself, his family sought treatment at their local community mental health center. After trying to harm his younger sister, though knowing it was wrong, Mike was admitted to a state psychiatric hospital. Mike's mother found the staff at the hospital to be very loving while setting limits on behavior. His 2-year stay at the hospital was very helpful to him. Today, Mike is in the 10th grade. He is on the wrestling team, involved in a bowling league and was recently asked to a Sadie Hawkins dance. Mike still participates in group therapy each week and is very helpful in drawing other people into active participation in the group. He has also expressed a desire to volunteer his time to read to people at a local nursing home. Mike, with help, has grown into a social young man who is able to succeed in a normal school setting, has demonstrated sound decision making and has plans for his future. Mike plans to attend IVY Tech upon graduation from high school.

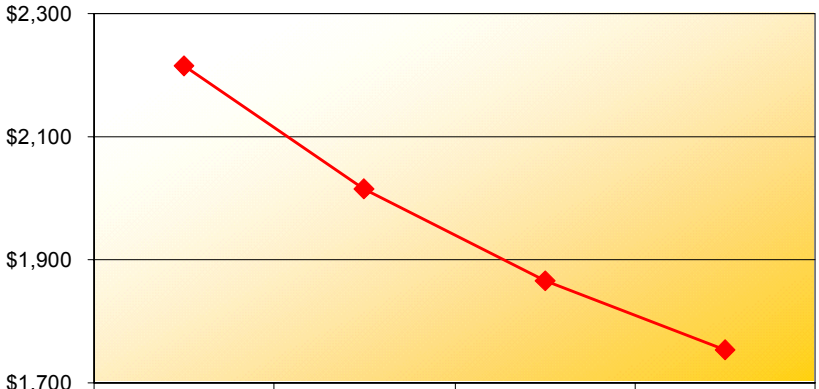
4 Community Programs

- Serving People
- Best Practices
- Special Populations
- Evidence Based Practices
- Programs
- Consumer Involvement & Advisory Councils

Serving People

The Family and Social Services Administration's Division of Mental Health and Addiction has increased community capacity for adults and children, serving more consumers in all areas of treatment. The number of HAP eligible consumers seeking treatment in the community has increased significantly from 75,478 in 2000 to 96,874 in 2003. As illustrated in the graph to the right, this increase in the number of persons served has not been matched by a proportional increase in funding. The budget for community services increased by only 1.6% while the number of people served increased by 28% over the four year period.

Community Funds Available Per Person



	SFY 2000	SFY 2001	SFY 2002	SFY 2003
Per person	$2,215	$2,016	$1,866	$1,753
# served	75,478	84,674	88,752	96,874

*Adults SMI, Child & Adolescent SED, Addictions, Prevention, Gambling from the line item appropriations
**SFY (State Fiscal Year)

Evidence Based Practices

The Division of Mental Health and Addiction is committed to achieving the best outcome possible for each individual seeking treatment. Our dedication to Evidence Based Practices (EBPs) is one way DMHA works toward increased recovery and improved outcomes. Evidence Based Practices are specific interventions that have been consistently shown, with scientific evidence, to improve outcomes for individuals with severe mental illness. Integrated Dual Diagnosis Treatment and Assertive Community Treatment are two Evidence Based Practices being utilized in Indiana.

Integrated Dual Diagnosis Treatment (IDDT)

The Division serves adults with mental illness or addiction. Often, adults served under the Hoosier Assurance Plan (HAP) have both illnesses. A 1998 study estimated that over 223,000 Hoosiers have a co-occurring mental illness and substance abuse disorder. Services for persons with a co-occurring mental illness and substance abuse disorder have been identified as a critical need. For several reasons, treatment for mental illness and treatment for substance abuse developed in parallel with little interaction between the two. This lack of coordinated care was not beneficial to those with a co-occurring disorder. To change the way persons with mental health and addiction illnesses are served,

the Division has supported Integrated Dual Diagnosis Treatment. IDDT is an evidence-based practice that integrates mental health and addiction services to consumers with co-occurring severe mental illness and addiction. IDDT is a team approach with assertive outreach and low caseload ratios. Clinicians on IDDT teams address both mental health and addiction rather than referring clients to two separate treatment providers. In 2003, there were six providers that started IDDT as part of a study with Dartmouth University. Staff at these sites are being trained and monitored by the Technical Assistance Center at Indiana University Purdue University Indianapolis (IUPUI), which is funded by DMHA.

Assertive Community Treatment (ACT)

Assertive Community Treatment is an intensive level of treatment that utilizes a team of professionals to serve a client that might otherwise require hospitalization. The ACT team is made up of a psychiatrist, a team leader, a nurse, substance abuse specialists, supported employment specialists, and other mental health professionals. The team works together to provide intensive services to help consumers with all aspects of living in the community, medication management, housing, independent living skills, counseling, employment, addiction treatment, and budgeting. The Division has contracted with the Technical Assistance Center to train ACT teams. In SFY 2003, 11 ACT teams were operating throughout the state serving over 420 people.

Best Practices

Best Practices are programs or practices that have been supported by expert opinion as appropriate treatment and are part of the community's standard of care. Best Practices are effective treatments but have not been part of a clinical trial like an Evidence Based Practice.

Supported Employment

Supported employment enables people with disabilities who have not been successfully employed to work. Employment for those with a mental illness is therapeutic. Often people with a mental illness who are employed have a reduction in symptoms, higher rates of compliance in taking their medication, a decrease in hospitalization, an increase in self-esteem and an enhanced quality of life. Supported employment focuses on a person's abilities and provides the supports the individual needs to be successful on a long-term basis. The Division of Mental Health and Addiction and the Office of Vocational Rehabilitation (OVR) combined funding to create establishment grants for CMHCs developing supported employment programs. DMHA and OVR continue to support the Supported Employment and Consultation Training (SECT) program at the Center for Mental Health in Anderson. SECT, established in 1995, provides training and consultation to the existing and developing supported employment programs across the state. The past decade has seen tremendous growth in supported employment. By the end of SFY 2003, 23 CMHCs had established supported employment services. In 1990, only one CMHC offered such services.

- Since 1995, 4,407 individuals have been served by the SECT Center.
- Most jobs found for people in Supported Employment services are in the service industry and pay an average of $6.50 an hour.

Systems of Care

For children who are in need of a high level of service, the Division is working to develop systems of care that provide intensive wraparound services. Developing systems of care in Indiana requires collaboration across many agencies, including the Family and Social Services Administration's Division of Mental Health and Addiction, Division of Family and Children, and Office of Medicaid Policy and Planning; the Department of Education; Juvenile Justice; and the Department of Correction. Systems of care programs represent a philosophical change in the way children with serious emotional disturbance (SED) and their families are treated. In a system of care program, the family is the chief decision-maker in how the child will be supported. For each child and their family, a team is formed; the team can be made up of relatives, neighbors, teachers, coaches, community mental health center staff, child welfare, or juvenile justice staff. All members know the child and are invested in improving the child's well-being. Team gatherings start with sharing successes, then challenges are discussed. This is fundamental to strength-based treatment, which focuses on the strengths of the child rather than on negative events or a diagnosis.

Dawn Project

The Dawn Project is a community-based wraparound system of care program. This Marion County program was recently highlighted as a "Model" program in the President's New Freedom Commission Interim Report. The project's mission is to provide new and improved levels of assistance to children with serious emotional disturbance (SED) and their families, helping them recover. Since 1996, the Dawn Project has helped over 700 kids and their families.

Indiana is one of the only states in the nation that has a Technical Assistance Center for Systems of Care and Evidence Based Practices for Children and Families. Contracted by the Division of Mental Health and Addiction, the Technical Assistance Center provides communities with the tools needed to develop and maintain systems of care in their service area.

Programs

Prevention

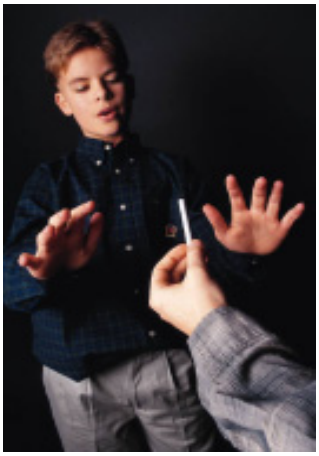
The Family and Social Services Administration's Division of Mental Health and Addiction targets all Hoosiers through our mental health promotion and addiction prevention programs.

Afternoons R.O.C.K. in Indiana

Nearly two-thirds of all new drug experimentation in Indiana begins between the end of 6th grade and the end of 9th grade. Afternoons R.O.C.K. in Indiana seeks to reach these youth and stop problems before they start. Developed by DMHA and the Indiana Prevention Resource Center, Afternoons R.O.C.K. provides youth with a prescribed strategy of structured and unstructured activities that promote positive social relationships and skills. Afternoons R.O.C.K. was designed to meet during the critical after school hours of 3-6 PM. Fourteen regional programs provide adult-supervised, after school prevention programs to youth ages 10-14. Programs are designed to teach youth about social and media influences, conflict resolution and refusal/resistance skills, gang and violence prevention, and the structuring of leisure time to be free of alcohol, tobacco and other drug use. In SFY 2003, over 13,000 youth were served by this program.

Prenatal Substance Use Prevention Program

The Division of Mental Health and Addiction collaborates with the Indiana State Department of Health (ISDH) and provides regional education-based prevention services to pregnant teens and adults. The program educates pregnant women about the effects of drugs on the fetus and drug-free alternatives. Alcohol, tobacco, or drug use during pregnancy can lead to low birth weight, premature birth, congenital anomalies, still birth, mental retardation or other neuro-behavioral effects. Participants in the program receive information, education services in clinics, and home visitations by Department of Health employees. An estimated 1,700 pregnant teens and adults were served in SFY 2003.



Indiana Grassroots Prevention Coalition

The Grassroots Initiative funds science-based prevention projects produced by coalitions of community based, volunteer-led organizations and supportive agencies. Sixteen sites have been conducting programs. A project evaluation conducted by The Center for Prevention Research and Development, University of Illinois ran through 2003. The Center will provide a report to the Office of the Governor by June 30, 2004.

Indiana Prevention Resource Center (IPRC)

The Indiana Prevention Resource Center, located at Indiana University, is partially funded by the Division of Mental Health and Addiction. The IPRC strives to support prevention professionals in their efforts to provide quality prevention programs throughout the state. One project, funded by DMHA, was the Alcohol, Tobacco and Other Drug Use Survey of Indiana Children and Adolescents. In 2003, a record 200,000 youth participated in this survey. Statewide statistics from this survey are reported publicly, and each participating school or school corporation receives a confidential report of their own aggregate statistics.

Project Aftermath: Crisis Mental Health Counseling

Project Aftermath offers counseling and support to anyone affected by a natural or man-made disaster. Counselors work to educate people on the natural reactions that many people have to exceptionally stressful events. Counselors can meet with individuals or groups to talk about their reactions to an event and to provide healthy ways to cope with negative feelings. Counselors also educate people on when to seek more help.

Courtesy of FEMA Photo Library

In addition to Project Aftermath, the Division of Mental Health and Addiction's All-Hazards Advisory Group was formed to work with the Indiana State Department of Health on a coordinated Disaster Response. The Division's goal is to assure that the State of Indiana is prepared to provide emergency mental health and substance abuse services in the event of a natural disaster or a terrorist attack.

The newly established Project Aftermath was utilized by many Hoosiers in the 2002-2003 Biennium. In September 2002, the south side of Indianapolis was devastated by tornadoes. In the weeks that followed, Project Aftermath served over 2,500 persons affected by these tornadoes. In 2003, widespread flooding in the state led to more than 40 counties being declared disaster areas. Project Aftermath saw over 6,200 persons affected by this flooding.

Special Populations

Treatment efforts are often targeted to distinct groups. The following listing highlights some of the special populations targeted by the Division of Mental Health and Addiction.

Women with Dependent Children

For women with dependent children, normal treatment efforts are supplemented with assistance in finding housing, day care while women are in treatment, legal and financial assistance, and assistance with domestic violence concerns. In SFY 2003, 2,359 chronically addicted women with dependent children were served by the Hoosier Assurance Plan in Indiana.

Gambling

A compulsive gambler is a person who meets the criteria for the diagnosis of pathological gambling and who continues to gamble despite repetitive harmful consequences. The box below outlines the gambling treatment efforts offered by the Division of Mental Health and Addiction.

DMHA's gambling treatment efforts have been concentrated in four major areas:

Toll Free Referral Line
This toll-free number is printed on riverboat admission tickets, all state lottery tickets, and advertised in other media markets. Call 1-800-994-8448 for a confidential referral.

Treatment
13 state-endorsed providers are currently offering compulsive gambling treatment services. Agencies must be approved by DMHA for a compulsive gambling treatment endorsement.

A Full Array of Care
A full array of care must be made available for persons presenting for services. These services include case management, inpatient care, intensive outpatient services, linkage with self-help groups, and financial management counseling.

Provider Support
DMHA has worked closely with the treatment providers to ensure quality services through specialized therapist training, technical assistance, and prevention and education efforts. The Indiana Problem Gambling Taskforce was established by DMHA and is charged with developing an efficient method for disseminating problem gambling information throughout the State of Indiana.

Methadone

The Division certifies and licenses all Opioid Treatment Programs (OTPs), commonly known as "methadone clinics." An OTP maintains procedures that are designed to ensure that patients are given access to treatment by qualified personnel. The Division provides partial financial support for methadone or levo-alpha-acetylmethadol hydrochloride (LAAM) treatment services in Lake and Marion counties. In 2002, the 12 opioid treatment programs in the state enrolled 8,144 patients (data for methadone clients is collected by calendar year).

Critical Populations

In order to serve groups who have been traditionally underserved, the Division established a Bureau for Critical Populations. Critical Populations are defined as those who have been underserved in the behavioral health services arena. These include, but are not limited to, African-Americans, Hispanics, Asian/Pacific Islanders, Native Americans, persons who are homeless, older adults, persons who are deaf or hearing impaired, migrants, and persons with HIV/AIDS. The Division established and maintains a network of relationships among a variety of consumers, providers, community organizations, advocates, agencies, and concerned citizens in order to enhance participation in Division programs, goals and objectives.

The Cultural Competency Action Training Project is a series of training sessions offered to providers. The goal of the training sessions is to assist Community Mental Health Centers and addiction providers in developing an organizational infrastructure to address cultural competency to improve treatment outcomes for the various cultural groups within their service regions. Understanding diversity is critical in order to build trust with a consumer and help them move toward recovery.

Boys-To-Men Mentor Program

This program, which began in 1992, allows State of Indiana employees to serve as role models for African-American male youth ages 6-18. As volunteers, mentors assist in the cultivation and development of positive self-esteem and academic achievements. In 2003, the mentor program focused on health and education for young men in the program. Participants continue to show improvement in education, grades, and in their knowledge of health issues related to smoking, nutrition, exercise, and non-violence.

Consumer Involvement and Advisory Councils

Office of Consumer and Family Affairs

The Office of Consumer and Family Affairs (OCFA) was established in April 2001 in order to assure that the interests of consumers and their families are represented at all levels of the Division of Mental Health and Addiction planning and policy development. The OCFA is committed to training consumers and families in effective advocacy skills. Advocacy and leadership training are a growing part of OCFA responsibilities. Advocacy training works to build the skills necessary to advocate on many levels, either to improve a consumers personal medical treatment plan or to bring people together to work toward systems change.

What is the *Olmstead* Decision?

"In June 1999, the Supreme Court ruled in L.C. & E.W. vs. *Olmstead* that it is a violation of the Americans with Disabilities Act for states to discriminate against people with disabilities by providing services in institutions when the individual could be served more appropriately in a community-based setting."

The States' Response To The Olmstead Decision: A Work In Progress Wendy Fox-Grage et. al.

Training seminars are offered through the Division of Mental Health and Addiction and address these different levels of advocacy. The OCFA partners on training seminars with the *Olmstead* Coalition of Marion County, a coalition of mental health organizations in Marion County. The *Olmstead* decision is fundamental to the drive to provide services to consumers in the least restrictive setting. In compliance with the Americans with Disabilities Act (ADA), states are moving individuals out of institutions and developing necessary services to support and maintain community integration and to provide alternatives to inpatient care.

Councils

The Division of Mental Health and Addiction Councils operate as advisory groups that provide a forum for consumers, family members, and advocates to work with the Division. The Division has a long history of securing input through advisory and planning councils.

Division of Mental Health and Addiction Advisory Council

Statutorily mandated group that was formed to advise the Division on critical mental health and addiction issues. Consumers, family members, providers and other interested stakeholders come together to form the membership of the Division of Mental Health and Addiction Advisory Council.

State Mental Health Planning Council

This council is required by the federal Mental Health Block Grant. The council is broken into three subcommittees:

Adults with Mental Illness Subcommittee
Children's Subcommittee
Critical Populations Subcommittee

Indiana Addiction Planning Council

This group was formed to help the state meet the federal requirement for public input into the annual application and implementation report for the federal Substance Abuse Prevention and Treatment Block Grant and to advise the DMHA on addiction issues. The council is also split into two subcommittees. In the 2002-2003 biennium each subcommittee addressed different issues:

Prevention Subcommittee - This committee reviewed the State Prevention Framework, assisted with identifying prevention priorities, and advised DMHA staff on community issues.

Treatment Subcommittee - This committee addressed workforce development, reducing stigma, improving and strengthening treatment, connecting research and practice and closing treatment gaps. The treatment subcommittee has also been integral in supporting and giving input on several federal grants that the state is pursuing.

Jennifer

Jennifer is a part-time paraprofessional in central Indiana. She also volunteers for the National Alliance for the Mentally Ill and is very excited about the recent grant that she wrote for their new peer-to-peer program. Jennifer knows that a program like peer-to-peer can make a big difference in people's lives, that the interaction and support it can provide are vital in the recovery process. She knows this from personal experience. She has a full life now but this was not always the case. Jennifer was in graduate school, studying to be a youth minister, when depression forced her to drop out of school. The following years were filled with multiple hospitalizations and struggles with alcoholism. After moving back to Indiana to be near her family, Jennifer began her journey to recovery. The support of her family and intensive treatment have enabled her to work part-time and rebuild her life.

Division of Mental Health and Addiction Consumer Council

The DMHA consumer council is composed of consumers and family members of consumers of mental health and addiction services. The council's purpose is to provide the consumer perspective for DMHA planning and policy development. One of the main objectives for the Consumer Council in SFY 2002-2003 was the transformation of the service system to a recovery oriented service system.

These councils bring together needed expertise in the field of mental health and addiction treatment. This expertise comes in many forms and from many backgrounds including, providers of mental health and addiction services, consumers of those services, and advocates for mental health and addiction consumers. The Division is grateful to all consumers, advocates, and family members who participate in these councils.

5 Future Plans

In February, 2003, the Division of Mental Health and Addiction conducted an in-depth study to gain input regarding the vision, values and priorities for mental health and addiction within Indiana. Feedback was collected from consumers, families, advocates, government leaders, providers, and community/state leaders and consolidated into the following plan for Indiana. Indiana's vision and goals are consistent with the New Freedom Commission Report.

Recovery Vision

We envision a future when everyone with mental illness or an addiction will recover, a future when mental illness can be prevented or cured, a future when mental illness and addiction are detected early, and a future when everyone with a mental illness or addiction at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community.

Desired Mental Health & Addiction Recovery Transformation in Indiana

- Improved consumer outcomes leading to increased self-sufficiency
- Focus on the goal of recovery and resilience
- Values driven
- Integrated services in the least restrictive setting possible
- Implementation of best practices
- Appropriate and effective utilization of resources

Shared Values

- Cost-effectiveness, measurement for quality improvement and accountability
  Reward progressive providers who accelerate consumer recovery
- Strength-based recovery/habilitation
  Focus on consumers' special abilities and continuously reinforce that recovery is possible
- Hope for the future
  Help people dream about what they want out of life and celebrate the achievements along the way
- Respect for people and reduction of stigma
  Foster honesty, cultural competency, and a mutual appreciation among consumers, families, providers, advocates, government, and the community
- Personal responsibility and self-sufficiency
  Consumers accelerate their own recovery, move out of the public mental health system and become taxpayers

2004/2005 Priorities

- Children's services
- Employment
- Recovery outcome results

Goals for Mental Health and Addiction Systems Transformation

- Americans understand that mental health and addiction treatment are essential to overall health
- Mental health care and addiction treatment are consumer and family driven
- Disparities in mental health and addiction services are eliminated
- Early mental health and addiction screening, assessment, and treatment are common practice
- Excellent addiction and mental health care is delivered and research is accelerated
- Technology is used to access addiction and mental health care and information

Glossary and Acronyms

Glossary

ACCREDITATION: A peer review process by which an organization is evaluated against established clinical, financial, and organizational standards on a regularly scheduled basis. In Indiana, JCAHO and CARF accredit mental health and addiction provider organizations.
ALLOCATION: As used in this report, the DMHA action determining dollars available to a particular activity.
APPROPRIATION: A legislative act authorizing the expenditure of a designated amount of public funds for a specific purpose.
ASSERTIVE COMMUNITY TREATMENT (ACT): an intensive mental health program model in which a multidisciplinary team of professional serves consumers who do not readily use clinic-based services, but who are often at high risk for psychiatric hospitalization.
ASSESSMENT INSTRUMENT: Used by the DMHA's managed care providers to establish clinical eligibility for the Hoosier Assurance Plan. Costs, service, and outcome data are measured by the two instruments, (1) the Hoosier Assurance Plan Instrument-Adults (HAPI-A), and (2) the Hoosier Assurance Plan Instrument-Children (HAPI-C).
BEHAVIORAL HEALTH CARE: Care and treatment for behavioral, emotional, and mental problems and disorders, including mental illness, alcohol and drug dependencies, addiction, mental retardation and developmental disabilities.
BLENDED FUNDING: A consolidation of various state and federal funds into one account.
BLOCK GRANT: An allotment of funds to the state each fiscal year in an amount based on the state's submitted plan. DMHA receives two federal block grants from SAMHSA, (1) the Community Mental Health Services (CMHS) block grant, and (2) the Substance Abuse Prevention and Treatment (SAPT) block grant. The CMHS block grant funds are to be expended only for the purpose of:

(A) Carrying out the plan submitted by the state providing comprehensive community mental health services to adults with SMI and children with SED;
(B) evaluating the programs and services carried out under the plan; and
(C) planning, administration, and educational activities related to providing services under the plan.

The SAPT block grant funds are to be expended only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities.

CASE MANAGEMENT: Goal-oriented activities that locate, facilitate, provide access to, coordinate, or monitor the full range of basic human needs, treatment, and service resources for individuals. Intensive case management assertively monitors those individuals at risk of noncompliance with beneficial treatment regimens.
CERTIFICATION: Governmental regulatory process that establishes good standing for certain health care practitioners and organizations or programs through evaluation of minimum standards and safety practices. The Division of Mental Health and Addiction certifies addiction services providers, community mental health centers, residential care providers, managed care providers, and sub-acute care units.
CHRONIC ADDICTIVE DISORDER (CA): Sometimes referred to as substance abuse (SA). A disorder in which:

(A) The individual has a substance-related disorder diagnosed under the DSM-IV (American Psychiatric Association, 2000);
(B) the individual experiences significant functional impairments in two of the following areas:
    - activities of daily living,
    - interpersonal functioning,
    - ability to live without recurrent use of chemicals, and/or
    - psychological functioning;
(C) the duration of the addiction has been in excess of 12 months. However, individuals who have experienced amnesic episodes (blackouts), or have experienced convulsions or other serious medical consequences of withdrawal from a chemical abuse, or who display significant dangerousness as a result of chemical use, do not have to meet the durational requirement; and
(D) in the professional opinion of the clinical staff of the MCP, the person is considered to be Chronically Addicted.

CHRONICALLY ADDICTED WOMAN WITH DEPENDENT CHILDREN OR PREGNANT:

(A) The individual shall meet the definition of Chronically Addicted; and
(B) have dependent children receiving child care, or be pregnant at the date of enrollment; or

(C) women who are attempting to regain custody of their children

COMMUNITY-BASED CARE: The assortment of health and social services provided to an individual or family in the community for the purpose of promoting, maintaining, and/or restoring health and self-sufficiency and minimizing the effects of illness and disability.

COMMUNITY MENTAL HEALTH CENTER (CMHC): A provider of mental health and addiction services that meets the following conditions:

(A) Is approved by the Division of Mental Health and Addiction;
(B) is organized for the purpose of providing multiple services for persons with mental illness or a chronic addictive disorder; and
(C) is operated by an approved entity described in IC 12-7-2-38.

COMPULSIVE GAMBLING ADDICTION: Disorder in which:

(A) An individual who meets criteria for Axis-1 diagnosis of pathological gambling as set out in the DSM-IV (American Psychiatric Association, 2000), Diagnosis 321.31, Pathological Gambling; and
(B) the individual continues gambling behavior despite repetitive harmful consequences.

CONSUMER: A person who has received or is receiving mental health or addiction services.

CONTINUUM OF CARE: As defined in IC 12-7-2-40.6, a range of services for mental health or addiction consumers assured by a community mental health center or a managed care provider.

CO-OCCURRING DISORDERS: Persons with co-occurring disorders of mental illness and substance abuse.

CRITICAL POPULATIONS: Critical populations include individuals/groups who have been under-served and/or omitted from receiving mental health and addiction services. This includes, but is not limited to: African Americans, Hispanics/Latino, Asian/Pacific Islanders, Native Americans, homeless, older adults, the deaf and hard-of-hearing, migrants, persons with physical disabilities, and persons with HIV/AIDS.

CULTURAL COMPETENCE: Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables this system, agency, or professionals to work effectively in cross-cultural situations.

DEVELOPMENTAL DISABILITY (DD): A disability which usually is first evident in infancy, childhood, or adolescence and which is characterized by delays in the acquisition of cognitive, language, motor, or social skills. Examples are mental retardation, epilepsy, and autism.

DSM-IV: The Diagnostic and Statistical Manual of Mental Disorders 4th Edition, developed by the American Psychiatric Association (2000), which defines and classifies mental and addictive disorders.

DUALLY DIAGNOSED: Refers to either (1) persons with a co-existing mental illness and substance abuse disorder, or (2) persons with a co-existing mental illness and a developmental disability.

EVIDENCE BASED PRACTICE (EBP): Specific interventions that have been consistently shown, with scientific evidence, to improve outcomes for individuals with Serious Mental Illness.

EXPENDITURE: Accounting of actual dollars spent during a specified time-period, usually a state fiscal year (SFY).

FEDERAL FISCAL YEAR (FFY): The one-year period of time from October 1 of one year to September 30 of the following year.

FUNDING: As used in this report, a term describing dollars allocated, appropriated, or expended, or a combination thereof.

GATEKEEPER: An entity actively involved in the evaluation, planning, treatment, and transition back into the community of an individual committed to a state behavioral health hospital administered by the Division of Mental Health and Addiction (DMHA). Gatekeepers include the community mental health centers, addiction treatment providers, a Division of Disability, Aging and Rehabilitation Services (DDARS) case manager, and the Division of Mental Health and Addiction.

HAPI-A: Hoosier Assurance Plan Instrument-Adult. Used by the DMHA's managed care providers to establish adult clinical eligibility for the Hoosier Assurance Plan. Costs, service, and outcome data are measured.

HAPI-C: Hoosier Assurance Plan Instrument-Child. Used by the DMHA's managed care providers to establish child and adolescent clinical eligibility for the Hoosier Assurance Plan. Costs, service, and outcome data are measured.

HOOSIER ASSURANCE PLAN (HAP): The Division of Mental Health and Addiction managed care strategy designed to reform the method of funding and the delivery of mental health and addiction services by the state of Indiana.

INTEGRATED DUAL DIAGNOSIS TREATMENT (IDDT): Evidence Based Practice that integrates mental health and addiction services to persons with co-occurring severe mental illness and addiction.

LICENSURE: Governmental regulatory process which establishes good standing for health care practitioners, organizations, or programs through evaluation of minimum standards and safety practices. The Division of Mental Health and Addiction licenses supervised group living facilities and private mental health institutions.

MANAGED CARE: Various strategies that seek to optimize the value of provided services by controlling their cost and utilization, promoting their quality, and measuring performance to ensure cost-effectiveness.

MEDICAID: A joint federal-state program which finances health care for low-income and/or categorically eligible people.

MEDICAID REHABILITATION OPTION (MRO): A means of paying for community-based outpatient and case management mental health services through community mental health centers for Medicaid-eligible persons using a combination of state and federal dollars.

MENTAL ILLNESS (MI): All forms of illness in which psychological, emotional, or behavioral disturbances are the dominating feature and which can substantially diminish the capacity for coping with ordinary demands of life. See "Serious Mental Illness."

METHADONE: An organic compound used in treating heroin and other opioid dependence.

OUTCOME MEASURES: A technology for measuring consumer experience designed to help consumers, payers, and providers make rational health care-related choices based on better insight into the effect of these choices on the consumer's life.

OUTPATIENT SERVICES: Services received by non-hospitalized persons consisting of periodic contact of short duration, including such activities as medication monitoring, ambulatory detoxification, social club, and individual, family, and group therapy.

PARTIAL HOSPITALIZATION: Ambulatory treatment, available four or more hours per day, four or more days per week, which offers major diagnostic, medical, psychiatric, psychosocial, pre-vocational, and educational modalities for patients with serious psychiatric disorders requiring coordinated, intensive, comprehensive multidisciplinary treatment not available in an outpatient clinical setting.

POVERTY: As defined by the federal government, a person is "in poverty" if the household in which the person resides has an annual income below a predetermined level.

PREVALENCE: In epidemiology, the total number of cases of a condition or illness in a given population over a specified period of time, usually a year.

PREVENTION: A multi-faceted proactive process consisting of education, consultation, and other activities that empower individuals and promote healthy behaviors and lifestyles.

PREVENTION ACTIVITIES: A structured series of activities designed to provide continuing services to participating youth from a target audience over a period of time sufficient to produce a predictable impact upon substance-using behavior.

PROVIDER PROFILE REPORT CARD: A report published annually by DMHA that assesses a provider's effectiveness related to delivery of purchased services, particularly accessibility and acceptability of services to consumers and value of the service determined by objective measurement of consumer-related outcomes.

RESIDENTIAL SERVICES: Services provided in a variety of 24-hour settings to consumers who can benefit from a comprehensive range of treatment and habilitative/rehabilitative services, including education, group, individual, and family and skills therapy. Category includes: Supervised Group Living (SGL), Alternative Family for Children and Adolescents (AFC), Alternative Family for Adults (AFA), Semi-independent Living programs (SILP), and Sub-acute Stabilization programs for mental health consumers, and transitional residential (halfway house) services for persons with chronic addictive disorders.

SERIOUS EMOTIONAL DISTURBANCE (SED; Less Than 18 Years of Age): Childhood disorder in which:

(A) The child has a mental illness diagnosis under the DSM-IV (American Psychiatric Association, 2000);

(B) the child experiences significant functional impairment in at least one of the following areas:
- activities of daily living,
- interpersonal functioning,
- concentration, persistence and pace, or
- adaptation to change;

(C) the duration of the disorder has been, or is expected to be, in excess of 12 months. Children who have experienced a situational trauma and who are receiving services in two or more community agencies do not have to meet the durational requirement; and

(D) in the professional opinion of the clinical staff of the MCP, the child is considered to be Seriously Emotionally Disturbed.

SERIOUS MENTAL ILLNESS (SMI): Adult disorder in which:

(A) The individual has a mental illness diagnosis under the DSM-IV (American Psychiatric Association, 2000);

(B) the individual experiences significant functional impairment in two of the following areas:
- activities of daily living,
- interpersonal functioning,
- concentration, persistence and pace, and/or
- adaptation to change; and

(C) the duration of the mental illness has been, or is expected to be, in excess of 12 months. Adults who have experienced a situational trauma do not have to meet the durational requirement; and

(D) in the professional opinion of the clinical staff of the MCP, the person is considered to be Seriously Mentally Ill.

SOF (STATE OPERATED FACILITY): These facilities are also referred to as state psychiatric hospitals.

STATE FISCAL YEAR (SFY): In Indiana, the one-year period of time from July 1 of one year to June 30 of the following year.
SUBSTANCE ABUSE (SA): See "Chronic Addictive Disorder."
SUPPORTED EMPLOYMENT PROGRAMS: Programs providing an array of services to help assure the successful participation of persons with a mental illness in competitive work.
SYSTEMS OF CARE (SOC): Evidence Based Practice in which the family and child are supported by a team of social service professions and family and friends.
TARGET POPULATIONS: Populations eligible for DMHA funding, which are: seriously mentally ill adults (SMI), seriously emotionally disturbed children and adolescents (SED), and persons with a chronic addictive disorder (CA or SA).
TREATMENT: Methods employed to attain, maintain, and/or re-establish emotional and/or physical health as well as maximum growth and adaptive capabilities.
WRAPAROUND: A process for planning the delivery of comprehensive child and family-centered services and supports through flexible service plans that tie interventions to the strengths of the individual, family, teacher, and other service providers.

Acronyms

ACT	Assertive Community Treatment
CA	Chronically Addicted or Chronic Addictive Disorder. May be referred to as SA or Substance Abuse.
CCATP	Cultural Competency Action Training Project
CHINS	Children in Need of Services
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services (federal)
CMHS	Community Mental Health Services (federal block grant)
CSAP	Center for Substance Abuse Prevention (federal)
CSAT	Center for Substance Abuse Treatment (federal)
CSDS	Community Services Data System
DD	Developmental Disability or Developmentally Disabled
DDARS	FSSA Division of Disability, Aging and Rehabilitative Services
DFC	FSSA Division of Family and Children
DMHA	FSSA Division of Mental Health and Addiction
DOC	Indiana Department of Correction
DOE	Indiana Department of Education
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
EPCC	Evansville Psychiatric Children's Center
ESH	Evansville State Hospital
FDA	Food and Drug Administration
FFY	Federal Fiscal Year
FPL	Federal Poverty Level
FSSA	Indiana Family and Social Services Administration
GAM	Compulsive Gambling Disorder
HAP	Hoosier Assurance Plan
HAPI-A	Hoosier Assurance Plan Instrument-Adults
HAPI-C	Hoosier Assurance Plan Instrument-Children
HUD	U.S. Department of Housing and Urban Development
IAC	Indiana Administrative Code
IC	Indiana Code
ICCMHC	Indiana Council of Community Mental Health Centers
ICF/MR	Intermediate Care Facilities/Mentally Retarded
ICMHSR	Indiana Consortium for Mental Health Services Research
ICST	Incompetent to Stand Trial
IPRC	Indiana University Prevention Resource Center
ISDH	Indiana Department of Health
IU	Indiana University
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KEY	Knowledge Empowers You
LCC	Local Coordinating Councils
LCH	Larue D. Carter Memorial Hospital
LSH	Logansport State Hospital
MI	Mental Illness. See Serious Mental Illness (SMI).
MRO	Medicaid Rehabilitation Option
MSH	Madison State Hospital
NASADAD	National Association State Alcohol and Drug Association Directors
NASMHPD	National Association of State Mental Health Program Directors
OMPP	FSSA Office of Medicaid Policy and Planning
OVR	Office of Vocational Rehabilitation
PATH	Programs for Assistance in Transition from Homelessness
P.L.	Public Law
RSH	Richmond State Hospital
SA	Substance Abuse. May be referred to as CA, or Chronic Addiction.

SAMHSA	Substance Abuse and Mental Health Services Administration (federal)
SAPT	Substance Abuse Prevention and Treatment (federal block grant)
SECT	Supported Employment Consultation and Training Center - Anderson CMHC
SED	Serious Emotional Disturbance, or Seriously Emotionally Disturbed
SFY	State Fiscal Year
SMI	Serious Mental Illness, or Seriously Mentally Ill. May be referred to as MI.
SOF	State Operated Facility. May be referred to as State Psychiatric Hospital.
SWD	Chronically Addicted Women with Dependent Children or Pregnant
TRIP	Tobacco Retail Inspection Program

Appendix

Persons Served in the Community SFY 2002 & 2003

Persons Served by Agreement Type

	SA/GAM	SED	SMI
SFY 2002	26233	20575	41944
SFY 2003	25825	23012	48037

***Living Arrangement at Enrollment**

	Incarcerated	Homeless	Dependent	Independent	Other
SFY 2002	764	2869	23574	56985	4560
SFY 2003	903	3120	22740	68238	1873

***Employment Status**

	Full Time	Part Time	Unemployed	Not in Labor Force	Unknown
SFY 2002	12062	7519	24300	19894	2931
SFY 2003	12271	8078	27113	23436	1565

HAP Consumers by Race

	Asian	African-American	Hawaiian	Multiple Race	Native American	Other	White
SFY 2002	141	13595	30	1018	357	2154	71457
SFY 2003	177	14454	37	1293	369	2251	78293

Persons Served by Age

	SFY 2002	SFY 2003
0-3	563	647
4-12	12857	14416
13-17	8626	9348
18-24	12599	13408
25-34	16912	18174
35-44	18509	19550
45-64	15795	17892
65-74	1756	1889
75 +	1135	1550

***Employment Status**

Full-time: working 35 or more hours per week
Part-time: working 20 or fewer hours per week
Unemployed: looking for work during the last 30 days or laid off from a job
Not in Labor Force: not looking for work during the last 30 days or a homemaker, student, disabled, retired or in an institution

***Living Arrangement**

Homeless: no fixed address; includes living in a shelter, in a car, on the street, etc.
Dependent: includes those in nursing homes, foster care, residential facilities, state institutions, or other supervised living.
Independent: those in a home, apartment, or mobile home
Incarcerated: includes those in a jail or correctional setting and those on home detention, work release or juvenile detention